Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BRYAN RADIOLOGY ASSOC
2700 OSLER BLVD
BRYAN TX 77802

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Number 54

MFDR Tracking Number
M4-13-0536-01

MFDR Date Received
October 23, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the table of disputed services: "…The shoulder exam was done after patient's injection. The exam should have been paid."

Amount in Dispute: $41.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Texas Mutual paid codes 73040-26 and 23350 but declined to pay 73030-26 as the CCI Edits indicate it is part of comprehensive code 73040...The exam (73030) could have been paid if the appropriate modifier had been used. No additional payment is due."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2012	73030-26	$ 41.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets forth the medical fee guideline for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits (EOB)
   - 435 – per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
   - 236 – no description provided on the EOB

- CAC 193 – original payment decision is being maintained
- 891 – no additional payment after reconsideration

Issues

1. Is the billed code 73030-26 separately payable?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

   Review of the CCI public files finds that procedure code 73030 is a component procedure of another service (73040) billed on the same day. Standards of medical/surgical practice apply. For that reason, procedure codes 73030 and 73040 are not separately payable. The use of an appropriate modifier may be allowed. A review of the submitted bill does not support that an appropriate modifier was appended to procedure code 73030 other than the professional component modifier, -26.

2. The requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution	March , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.